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State/Territory Name: Iowa

State Plan Amendment (SPA) #: IA-25-0011

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) Form CMS-179
- 3) Approved SPA Pages



Medicaid and CHIP Operations Group

March 11, 2026

Lee Grossman, Medicaid Director
Iowa Medicaid
Iowa Department of Health and Human Services
321 E. 12th Street
Des Moines, Iowa 50319

RE: TN 25-0011 §1915(i) Home and Community-Based Services (HCBS) Habilitation State Plan Amendment (SPA)

Dear Director Grossman:

The Centers for Medicare & Medicaid Services (CMS) is approving the state's request to amend its 1915(i) state plan home and community-based services (HCBS) benefit, transmittal number TN 25-0011. The effective date for this amendment is January 1, 2026. With this amendment, the state made technical edits and removed the FA-1 performance measure.

Enclosed are the following approved SPA pages that should be incorporated into your approved state plan:

- Attachment 3.1-C Pages 3, 8-9, 13, 22-26, 27e-27g, 28, 30, 34-35, 40-41, 43-46, 55, 57-60, 64-65, 67-68, 70-71, 73, 75-79, 83

CMS reminds the state that the state must have an approved spending plan in order to use the money realized from section 9817 of the ARP. Approval of this action does not constitute approval of the state's spending plan.

It is important to note that CMS' approval of this change to the state's 1915(i) HCBS state plan benefit solely addresses the state's compliance with the applicable Medicaid authorities. CMS' approval does not address the state's independent and separate obligations under federal laws including, but not limited to, the Americans with Disabilities Act, Section 504 of the Rehabilitation Act, or the Supreme Court's Olmstead decision. Guidance from the Department of Justice concerning compliance with the Americans with Disabilities Act and the Olmstead decision is available at http://www.ada.gov/olmstead/q&a_olmstead.htm.

If you have any questions concerning this information, please contact me at (410) 786-7561. You may also contact Essence McKnight at essence.mcknight@cms.hhs.gov or (214) 210-1006.

Sincerely,

George P. Failla, Jr., Director
Division of HCBS Operations and Oversight

Enclosure

cc: Lee Herko, CMS
Bernice Denbow, CMS

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL
FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES**

1. TRANSMITTAL NUMBER

2 5 — 0 0 1 1

2. STATE

IA

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT

XIX XXI

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE

January 1, 2026

5. FEDERAL STATUTE/REGULATION CITATION

Section 1915(i) of the Act
42 CFR §441.700

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)

a. FFY 25 \$ 0
b. FFY 26 \$ 0

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 3.1-C Pages 3, 8-9,13, 22-26, 27e-27g, 28, 30, 34-35,
40-41, 43-46, 55, 57-60, 64-65, 67-68, 70-71, 73, 75-79, 83
Attachment 3.1-C Pages 26a, 35a, 37-37b, 38, 38a, 41a, 47, 48,
and 61

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (If Applicable)

Supersedes - Attachment 3.1-C Pages 3, 8-9,13, 22-26,
27e-27g, 28, 30, 34-35, 40-41, 43-46, 55, 57-60, 64-65,
67-68, 70-71, 73, 75-79, 83

9. SUBJECT OF AMENDMENT

Technical changes to Iowa Medicaid's 1915(i) State Plan Habilitation Services program.

10. GOVERNOR'S REVIEW (Check One)

- GOVERNOR'S OFFICE REPORTED NO COMMENT
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

OTHER, AS SPECIFIED:

11. CONTACT NAME

12. TYPED NAME
Rebecca Curtiss

13. TITLE
Medicaid Deputy Director of Operations

14. DATE SUBMITTED
12/19/2025

15. RETURN TO

FOR CMS USE ONLY

16. DATE RECEIVED
December 30, 2025

17. DATE APPROVED
March 11, 2026

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
January 01, 2026

19. SIGNATURE OF APPROVING OFFICIAL

20. TYPED NAME OF APPROVING OFFICIAL
George P. Failla, Jr.

21. TITLE OF APPROVING OFFICIAL
Director, Division of HCBS Operations and Oversight

22. REMARKS

3.11.26: State authorize P&I change to box 7.

4. Distribution of State plan HCBS Operational and Administrative Functions.

X (By checking this box the state assures that): When the Medicaid agency does not directly conduct an administrative function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. When a function is performed by an agency/entity other than the Medicaid agency, the agency/entity performing that function does not substitute its own judgment for that of the Medicaid agency with respect to the application of policies, rules and regulations. Furthermore, the Medicaid Agency assures that it maintains accountability for the performance of any operational, contractual, or local regional entities. In the following table, specify the entity or entities that have responsibility for conducting each of the operational and administrative functions listed (check each that applies):

(Check all agencies and/or entities that perform each function):

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
1. Individual State plan HCBS enrollment	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Eligibility evaluation	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Review of participant service plans	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Prior authorization of State plan HCBS	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. Utilization management	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6. Qualified provider enrollment	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
7. Execution of Medicaid provider agreement	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Establishment of a consistent rate methodology for each State plan HCBS	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
9. Rules, policies, procedures, and information development governing the State plan HCBS benefit	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
10. Quality assurance and quality improvement activities	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

(Specify, as numbered above, the agencies/entities (other than the SMA) that perform each function):

1. Individuals are assisted with enrolling in the state plan HCBS Habilitation services through the Iowa Medicaid’s Health Link managed care organizations (MCO) or the case manager.
2. The Department of Human Services’ Income Maintenance Worker determines if the member is eligible for Medicaid and determines the member’s income level. The Iowa Medicaid’s Medical Services Unit determines if the member meets the needs-based criteria also referred to as the non-financial criteria for enrollment in state plan HCBS. MCOs complete the initial assessment tools and annual reassessment tools for their enrolled membership and provides the information to the Iowa Medicaid Medical Services Unit; the Medical Services Unit evaluates and annually reevaluates the member’s eligibility maintaining review and approval authority.

3. **Process for Performing Evaluation/Reevaluation.** Describe the process for evaluating whether individuals meet the needs-based State plan HCBS eligibility criteria and any instrument(s) used to make this determination. If the reevaluation process differs from the evaluation process, describe the differences:

The Iowa Medicaid provides financial eligibility data daily to the MCOs. A member requesting Habilitation services must be Medicaid eligible and have income that does not exceed 150% FPL.

It is the responsibility of the case manager (CM), or community-based case manager (CBCM) to ensure the assessment is initiated as required to complete the initial needs-based eligibility determination. The initial LOCUS/CALOCUS assessment is completed by the Core Standardized Assessment (CSA) contractor and then sent to the CM/ CBCM who uploads the assessment to the Iowa Medicaid MSU. The Iowa Medicaid MSU is responsible for determining the needs-based eligibility based on the completed assessment scoring tool, the comprehensive assessment and social history as well as any other supporting documentation as applicable.

If the member meets the criteria, Habilitation is approved and the MCO, CM/CBCM are notified. The CM/CBCM coordinates the interdisciplinary team meeting to develop the service plan. Once developed, the service plan is submitted to the MCO for Health Link enrollees, or the Medical Services Unit for fee-for-service enrollees for service authorization.

This process is repeated annually or more often as the member's circumstances or situation dictates to determine continued eligibility and to reauthorize services.

The Continued Stay Review (CSR) is completed annually and uses the same assessment tool as is used with the initial needs-based eligibility determination. It is the responsibility of the service worker, case manager, or community-based case manager to ensure the assessment is initiated as required to complete the CSR. For fee-for-service participants, the IoWANS system sends out a milestone 60 days prior to the CSR date to remind service workers and case managers of the upcoming annual reevaluation of need-based eligibility process.

MCOs complete the initial assessment tools and annual reassessment tools annually, and when the MCO becomes aware that the member's functional or medical status has changed in a way that may affect needs-based eligibility for their enrolled membership and provides the information to the Iowa Medicaid Medical Services Unit. The Medical Services Unit initially evaluates and annually reevaluates the member's eligibility maintaining review and approval authority. Additionally, any member or provider can request a reassessment when the member's functional or medical status has changed in a way that may affect service utilization. Once the reassessment is complete, the MCO submits the assessment tool and other supporting documentation via upload to the Iowa Medicaid MSU. The State retains authority for determining Medicaid categorical, financial, needs based eligibility or needs-based eligibility and enrolling participants into a Medicaid eligibility category. CSA vendor tracks and reports assessment and reassessment data, including, but not limited to, reassessment completion date. The Iowa Medicaid MSU completes the reevaluation and determines needs-based eligibility. As the State is a neutral third party with approval authority, there is no conflict of interest.

4. **Reevaluation Schedule.** *(By checking this box the state assures that):* Needs-based eligibility reevaluations are conducted at least every twelve months.

5. **Needs-based HCBS Eligibility Criteria.** *(By checking this box the state assures that):* Needs-based criteria are used to evaluate and reevaluate whether an individual is eligible for State plan HCBS.

The criteria take into account the individual's support needs, and may include other risk factors: *(Specify the needs-based criteria):*

The individual needs assistance demonstrated by meeting at least two of the following criteria on a continuing or intermittent basis for at least twelve months

- The individual needs assistance to obtain and/or maintain employment.
- The individual needs financial assistance to reside independently in the community.
- The individual needs significant assistance to establish or maintain a personal social support system.
- The individual needs assistance with at least one activities of daily living (ADLs) or instrumental activities of daily living (IADLs) to reside independently in the community.
- The individual needs assistance with management and intervention of maladaptive or anti-social behaviors to ensure the safety of the individual and/or others.

AND The individual meets at least one of the following risk factors:

- A history of inpatient, partial hospitalization, or emergency psychiatric treatment more than once in the individual's life; or
- The individual has a history of continuous professional psychiatric supportive care other than hospitalization; or
- The individual has a history of involvement with the criminal justice system; or
- Services available in the individual's community have not been able to meet the individual's needs; or
- The individual has a history of unemployment or employment in a sheltered setting or poor work history; or
- The individual has a history of homelessness or is at risk of homelessness

6. **Needs-based Institutional and Waiver Criteria.** *(By checking this box the state assures that):* There are needs-based criteria for receipt of institutional services and participation in certain waivers that are more stringent than the criteria above for receipt of State plan HCBS. If the state has revised institutional level of care to reflect more stringent needs-based criteria, individuals receiving institutional services and participating in certain waivers on the date that more stringent criteria become effective are exempt from the new criteria until such time as they no longer require that level of care. *(Complete chart below to summarize*

- b. The setting is selected by the individual among all available alternatives and identified in the person-centered service plan;
- c. An individual's essential personal rights of privacy, dignity and respect, and freedom from coercion and restraint are protected;
- d. Individual initiative, autonomy and independence in making major life choices, including but not limited to, daily activities, physical environment, and with whom to interact are optimized and not regimented;
- e. Individual choice regarding services and supports, and who provides them, is facilitated;
- f. Any modifications of the conditions (for example to address the safety needs of an individual with dementia) must be supported by a specific assessed need and documented in the person-centered service plan;
- g. The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the State, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, there must be a lease, residency agreement, or other form of written agreement in place for each HCBS participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law;
- h. Each individual has privacy in their sleeping or living unit.
- i. Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors;
- j. Individuals sharing units have a choice of roommates in that setting;
- k. Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement;
- l. Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time;
- m. Individuals are able to have visitors of their choosing at any time; and
- n. The setting is physically accessible to the individual.

Settings:

Home Based Habilitation services can be provided in the following settings:

- Individual member's homes of any type (houses, apartments, condominiums, etc.).
- Members living in their family home of any type.
- Integrated community rental properties available to anyone within the community.

Provider-owned or controlled residential settings including:

- DIAL licensed Residential Care Facility (RCF) 16 beds or less.
- DIAL licensed Assisted Living Facility
- Host Home
- Home Based Habilitation Daily Site
- Intensive Residential Habilitation Service (IRHS) Home

6. Supporting the Participant in Development of Person-Centered Service Plan. Supports and information are made available to the participant (and/or the additional parties specified, as appropriate) to direct and be actively engaged in the person-centered service plan development process. *(Specify: (a) the supports and information made available, and (b) the participant's authority to determine who is included in the process):*

- (a) The service plan or treatment plan is developed by the participant and his or her interdisciplinary team based on information from the needs-based assessment, and taking into account the participant's social history, and treatment and service history. The case manager or MCO community-based case manager acts as an advocate for the participant in this process and is a source of information for the participant and the team. The participant and the team identify the participant's strengths, needs, preferences desired outcomes, and his or her desires in order to determine the scope of services needed. The case manager or MCO community-based case manager informs the participant of all available Medicaid and non-Medicaid services. The participant is encouraged to choose goals based on his or her own desires while recognizing the need for supports to attain those goals.
- (b) The interdisciplinary team includes the participant, his or her legal representative if applicable, the case manager or MCO community-based case manager, and any other persons the participant chooses, which may include service providers. Individuals that are not Medicaid providers are not reimbursed for their participation.
- (c) The FFS CM or the member's MCO ensures that the comprehensive service plan :
 - a. Includes people chosen by the member.
 - b. Provides necessary information and support to the member to ensure that the member directs the process to the maximum extent possible.
 - c. Is timely and occurs at times and locations of convenience to the member.
 - d. Reflects cultural considerations and uses plain language.
 - e. Includes strategies for solving a disagreement.
 - f. Offers choices to the member regarding services and supports the member receives and from whom.
 - g. Provides method to request updates.
 - h. Is conducted to reflect what is important to the member to ensure delivery of services in a manner reflecting personal preferences and ensuring health and welfare.
 - i. Identifies the strengths, preferences, needs (clinical and support), and desired outcomes of the member.
 - j. May include whether and what services are self-directed.
 - k. Includes individually identified goals and preferences related to relationships, community participation, employment, income and savings, healthcare and wellness, education and others.
 - l. Includes risk factors and plans to minimize them.
 - m. Is signed by all individuals and providers responsible for its implementation and a copy of the plan must be provided to the member and the member's representative.

The FFS CM or the member's MCO ensures that the written comprehensive service plan documentation:

- a. Reflects the member's strengths and preferences.
- b. Reflects clinical and support needs.
- c. Includes observable and measurable goals and desired outcomes.

- d. Identify interventions and supports needed to meet those goals with incremental action steps, as appropriate.
- e. Identifies the staff people, businesses, or organizations responsible for carrying out the interventions or supports.
- f. Identifies for a member receiving Supported community living:
 - a. The member's living environment at the time of enrollment,
 - b. The number of hours per day of on-site staff supervision needed by the member, and
 - c. The number of other members who will live with the member in the living unit.
- g. Reflects providers of services and supports, including unpaid supports provided voluntarily in lieu of state plan HCBS, including:
 - a. Name of the provider
 - b. Service authorized
 - c. Units of service authorized
- h. Includes risk factors and measures in place to minimize risk.
- i. Includes individualized backup plans and strategies when needed.
- j. Identifies any health and safety issues that apply to the member based on information gathered before the team meeting, including a risk assessment.
- k. Identifies an emergency backup support and crisis response system to address problems or issues arising when support services are interrupted or delayed or the member's needs change.
- l. Providers of applicable services shall provide for emergency backup staff.
- m. Includes individuals important in supporting the member.
- n. Includes the names of the individuals responsible for monitoring the plan.
- o. Is written in plain language and understandable to the member.
- p. Documents who is responsible for monitoring the plan.
- q. Documents the informed consent of the member for any restrictions on the member's rights, including maintenance of personal funds and self-administration of medications, the need for the restriction, and either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.
- r. Any rights restrictions must be implemented in accordance with 441 IAC 77.25(4).
- s. Includes the signatures of all individuals and providers responsible.
- t. Is distributed to the member and others involved in the plan.
- u. Includes purchase and control of self-directed services.
- v. Excludes unnecessary or inappropriate services and supports.
- w. Describes how a participant is informed of services available under the State Plan.

7. **Informed Choice of Providers.** *(Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the 1915(i) services in the person-centered service plan):*

The case manager, MCO community-based case manager informs the participant and his or her interdisciplinary team of all available qualified providers. This is part of the interdisciplinary team process when the service plan is developed, and again whenever it is renewed or revised. Participants are encouraged to meet with the available providers before choosing a provider.

8. **Process for Making Person-Centered Service Plan Subject to the Approval of the Medicaid Agency.** *(Describe the process by which the person-centered service plan is made subject to the approval of the Medicaid agency):*

The Iowa Department of Health and Human Services has developed a computer system named the Institutional and Waiver Authorization and Narrative System (IoWANS) to support certain Medicaid programs. This system assists with tracking information and monitoring the service plan

and enforces parameters such as unit and rate caps set by the department.

For 1915(i) participants who are not enrolled with an MCO through the Iowa HealthLink, the case manager initiates a request for services through this system, and Iowa Medicaid staff responds to the request for 1915(i) services. Case managers complete the assessment of the need for services and submit it to the Iowa Medicaid Medical Services Unit for evaluation of program eligibility. The case manager is also responsible for entering the service plan information such as the services to be received, the effective dates, the amount of each service, and the selected provider into IoWANS, where it is reviewed for authorization by Iowa Medicaid Medical Services staff.

For 1915(i) participants who are enrolled in the Iowa HealthLink, the MCOs have established a process for reviewing treatment plans and authorizing units of services. A determination is made by the MCO for the appropriate services and units based on the assessment, treatment plan and other services the member may be receiving. The State reviewed the MCO service planning process during the readiness review and retains oversight of the MCO person-centered service planning process through a variety of monitoring and oversight strategies as described in the Quality Improvement Strategy Section.

9. **Maintenance of Person-Centered Service Plan Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §74.53. Service plans are maintained by the following (*check each that applies*):

<input type="checkbox"/>	Medicaid agency	<input type="checkbox"/>	Operating agency	<input checked="" type="checkbox"/>	Case manager
<input checked="" type="checkbox"/>	Other (<i>specify</i>):	The case manager maintains service plans for fee-for-service members. MCO community-based case managers maintain MCO member service plans.			

Services

1. **State plan HCBS.** (*Complete the following table for each service. Copy table as needed*):

Service Specifications (<i>Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover</i>):	
Service Title:	HCBS Case Management
Service Definition (Scope):	
Services that assist participants in gaining access to needed waiver and other State plan services, as well as medical, social, educational, and other services, regardless of the funding source for the services to which access is gained. Individuals who receive Targeted Case Management under the Medicaid State plan cannot also receive case management under Section 1915(i). Reimbursement is not available for case management under multiple authorities. Because individuals can only be enrolled in one case management program, duplicate billing is avoided. Participants are free to choose their provider.	
Additional needs-based criteria for receiving the service, if applicable (<i>specify</i>):	
Participants have a need for support and assistance in accessing services.	
Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.	
<i>(Choose each that applies)</i> :	

<input type="checkbox"/> Categorically needy (<i>specify limits</i>): 			
<input type="checkbox"/> Medically needy (<i>specify limits</i>): 			
Provider Qualifications (<i>For each type of provider. Copy rows as needed</i>):			
Provider Type (<i>Specify</i>):	License (<i>Specify</i>):	Certification (<i>Specify</i>):	Other Standard (<i>Specify</i>):
Case Management Provider		<p>Providers must be certified under Iowa Administrative Code 441-24, which includes meeting the following qualifications:</p> <ol style="list-style-type: none"> Has a bachelor’s degree with 30 semester hours or equivalent semester hours or equivalent quarter hours in a human services field (including but not limited to, psychology, social work, mental health counseling, marriage and family therapy, nursing, education, occupational therapy, and recreational therapy) and at least one year of experience in the delivery of relevant services. <p style="text-align: center;">-Or-</p> <ol style="list-style-type: none"> Has an Iowa license to practice as a registered nurse and at least three years of experience in the delivery of relevant services. 	<p>Case Management Provider</p> <ul style="list-style-type: none"> - Case Management services are delivered pursuant to 441 IAC chapter 90. - Case Managers must have at least one face-to-face contact per month for the first three months of enrollment. This requirement applies when a case management-eligible individual newly enrolls with Case Management or when an existing individual first becomes eligible for Case Management. - Following the first three months, the Case Manager must complete at least one contact per month with the individual or their authorized representative.

			<ul style="list-style-type: none">- If the individual is authorized to receive HCBS Habilitation services who have been diagnosed with an Intellectual and/or Developmental Disability, Case Managers must complete at least one, in-home, face-to-face contact every other month. - For those who are not diagnosed with Intellectual and/or Developmental Disability, the Case Manager must complete at least one, in-home, face-to-face contact every three months. - When an individual is authorized to receive HCBS Habilitation services in a provider owned or controlled Home-based Habilitation residential setting and is under the age of 18, the Case Manager must complete at least one, in-home, face-to-face contact every other month.
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Verification of Provider Qualifications *(For each provider type listed above. Copy rows as needed):*

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Provider Type (Specify):	Entity Responsible for Verification (Specify):	Frequency of Verification (Specify):
Case Management Provider	Iowa Department of Health and Human Services, Iowa Medicaid	Verified at initial certification and thereafter based on the length of the certification (either 270 days, 1 year, or 3 years)
Service Delivery Method. (Check each that applies):		
<input type="checkbox"/>	Participant-directed	<input checked="" type="checkbox"/> Provider managed

Service Specifications (Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):	
Service Title:	Habilitation
Service Definition (Scope):	
<p>Services designed to assist participants in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings.</p> <p>Components of this service include the following:</p> <p>Home-based Habilitation means individually tailored supports that assist with the acquisition, retention, or improvement in skills related to living, working and recreating in the community. Home-based habilitation services are individualized supportive services provided in the member's home and community that assist the member to reside in the most integrated setting appropriate to the member's needs. Services are intended to provide for the daily living needs of the member and shall be available as needed during any 24-hour period. The specific support needs for each member shall be determined necessary by the interdisciplinary team and shall be identified in the member's comprehensive service plan. Covered supports include:</p> <ol style="list-style-type: none"> 1) Adaptive skill development; 2) Assistance with activities of daily living to address daily living needs; 3) Assistance with symptom management and participation in mental health treatment; 4) Assistance with accessing physical and mental health care treatment, communication, and implementation of health care recommendations and treatment; 5) Assistance with accessing and participating in substance use disorder treatment and services; 6) Assistance with medication administration and medication management; 7) Assistance with understanding communication whether verbal or written; 8) Community inclusion and active participation in the community; 9) Transportation; 10) Adult educational supports, which may include assistance and support with enrolling in educational opportunities and participation in education and training; 11) Social and leisure skill development; 12) Personal care; and 13) Protective oversight and supervision. 	

Setting requirements. Home-based habilitation services shall occur in the member's home and community.

- Respect and always maintain the individual's privacy, including when scheduled or intermittent/as-needed support includes responding to an individual's health, safety, and other support needs for personal cares.
- Only use cameras in bedrooms or bathrooms when the IDT has identified a specific support need directly related to the member's health or safety risk in the person-centered service plan and the member, and their legal representative has given informed consent for the use of cameras in the member's bedroom or bathroom to specifically mitigate the risk when in-person supports are not present.
 - For members who share a bathroom, each member must have an identified health or safety risk justifying the use of the camera and each must provide informed consent for the use of the camera. For members for whom there is not an identified health or safety need for cameras in the bathroom and for whom there is no informed consent for the use of a camera in the bathroom, the camera must have the functionality that allows it to be shut off by the member or the Remote Support Professional while that member is using the bathroom.
 - For members sharing a bedroom, each member must consent to the placement of a camera in the bedroom. If both members do not consent, then the camera may not be placed in the bedroom.

The member's case manager or community-based case manager is responsible for ensuring that the HBH provider agency has provided the appropriate training on the use of the technology and equipment within the home including the how to disable or shut off the technology and equipment including cameras and monitors as needed prior to initiation of HBH remote service delivery. The record of the training that occurs with the member on the use of the technology and equipment will be documented in the member's service record and reviewed regularly by the case manager or community-based case manager.

The individual's case manager or community-based case manager is responsible for monitoring the services in the person-centered service plan which includes at a minimum monthly contact with the individual or their representative and visiting individuals in their place of residence on a quarterly basis. As part of the monitoring activities the case manager or community-based case manager will review the receipt of HBH with the member and ensure that the delivery of HBH through remote support continues to meet the individual's service needs. This regular review will include a review of the member's use of the equipment, informed consent for the mode of service delivery and the overall satisfaction with the delivery of HBH remotely. The HCBS QIO and the MCOs also provide oversight of service delivery through the quality monitoring and oversight of the HBH providers.

The agency service provider responsible for responding to an individual's health, safety, and other support needs through remote support must:

1. Ensure the use of enabling technology complies with relevant requirements under the Health Insurance Portability and Accountability Act (HIPAA).
2. Comply with the data privacy laws, restrictions and guidelines.

3. Ensure that service documentation occurs during remote support delivery in accordance with the 441-79.3

HBH Host Home Service Delivery Model

A Host Home is a community-based family home setting whose owner or renter provides home and community-based services (HCBS) Home-Based Habilitation services to no more than (2) individuals who reside with the owner or renter in their primary residence and is approved for those services as an independent contractor of a community-based HBH service agency.

Host Home is an available service delivery option through the HBH service to meet a member's health, safety and other support needs as needed when it:

- *Is chosen and preferred as a service delivery method by the person or their guardian (if applicable)
- *Appropriately meets the member's assessed needs.
- *Is provided within the scope of the service being delivered.
- *Is provided as specified in the member's support plan.

HBH delivered in a Host Home Service Requirements

Assessment

Through an assessment by the HBH agency provider with input from the member and their Interdisciplinary Team (IDT) the member's ability to be supported safely through the Host Home model is identified.

Through an assessment by the HBH agency provider with input from the individual and their IDT, the desired location of the Host Home will be determined to best meet the member's needs.

Through an assessment by the HBH agency provider of potential Host Home Hosts, potential matching Host Homes will be identified.

Informed Consent

Informed consent of delivery of HBH in the Host Home by the Host Home provider by the individual using the service, their guardian must be obtained. Each member, guardian and IDT must be made aware of both the benefits and risks of the Host Home service delivery model.

Informed consent documents must be acknowledged in writing, signed, and dated by the individual, guardian, case manager and provider agency representative, as appropriate. A copy of the consent shall be maintained by the case manager, the guardian (if applicable) and in the provider agency file.

If the individual desires to withdraw consent, sever the residential agreement, and transfer from the Host Home to a provider owned and controlled HBH setting, the member, their guardian or the Host must notify the HBH provider agency and the member's case manager. A meeting of the IDT would be needed to discuss available options for any necessary alternative services and supports.

Privacy

Host Home HBH service providers must:

- * Respect and always maintain the member's privacy, including when the person is in settings typically used by the public.
- * Respect and always maintain the member's privacy, including when scheduled or intermittent/as-needed support includes responding to a member's health, safety, and other support needs for personal cares.

Members may choose to receive HBH through the telehealth service delivery option. Providers delivering HBH through the Telehealth* delivery option must demonstrate policies and procedures that include:

- Compliance with all state requirements related to telehealth as described in Iowa Code 514c.34
- HIPAA compliant platforms.
- Client support given when client needs include accessibility, translation, or limited auditory or visual capacities are present.
- Have a contingency plan for provision of services if technology fails.
- Professionals do not practice outside of their respective scope; and
- Assessment of clients and caregivers that identifies a client's ability to participate in and outlines any accommodations needed while using Telehealth.
- In-person visit is not a prerequisite for the delivery of HBH through Telehealth.

*"Telehealth" means the delivery of HBH services through the use of real-time interactive audio and video, or other real-time interactive electronic media, regardless of where the health care professional and the covered person are each located. "Telehealth" does not include the delivery of health care services delivered solely through an audio-only telephone, electronic mail message, or facsimile transmission.

HBH services delivered via telehealth will be delivered in a setting or location that protects the Habilitation participants privacy and may not occur in settings such as a bathroom.

The in-person delivery of HBH by a direct support professional and the delivery of HBH through telehealth or remote support professional may not occur at the same time.

Enabling Technology for Remote Support

"Enabling technology" means the technology that makes the on demand remote supervision and support possible and includes a device, product system, or engineered solution whether acquired commercially, modified, or customized that addresses an individual's needs and outcomes identified in his or her individual service plan. The service is for the direct benefit of the individual in maintaining or improving independence and functional capabilities. Remote support and monitoring will assist the individual to fully integrate into the community, participate in community activities, and avoid isolation.

Prevocational services means services that provide career exploration, learning and work experiences, including volunteer opportunities, where the member can develop non-job-task-specific strengths and skills that lead to paid employment in individual community settings.

Prevocational services are provided to persons who are expected to be able to join the general workforce with the assistance of supported employment. Prevocational services are intended to develop and teach general employability skills relevant to successful participation in individual employment. These skills include but are not limited to:

- The ability to communicate effectively with supervisors, coworkers and customers,
- An understanding of generally accepted community workplace conduct and dress,
- The ability to follow directions,
- The ability to attend to tasks,
- Workplace problem-solving skills and strategies,
- General workplace safety and mobility training,
- The ability to navigate local transportation options,
- Financial literacy skills, and
- Skills related to obtaining employment.

Prevocational services include career exploration activities to facilitate successful transition to individual employment in the community. Participation in prevocational services is not a prerequisite for individual or small-group supported employment services.

ensure informed choice, after which the choice to receive small-group supported employment services was made.

(5) Not reside in a medical institution.

Community transportation options (e.g., transportation provided by family, coworkers, carpools, volunteers, self or public transportation) shall be identified by the member's interdisciplinary team and utilized before the service provider provides the transportation to and from the service site for the member. If none of these options are available to a member, transportation between the member's place of residence and the service location may be included as a component part of prevocational services.

Personal care or personal assistance and protective oversight may be a component part of prevocational services, but may not comprise the entirety of the service

Supported Employment

Individual Supported Employment

Individual supported employment involves supports provided to, or on behalf of, the member that enable the member to obtain and maintain individual employment. Services are provided to members who need support because of their disabilities.

Individual supported employment services are services provided to, or on behalf of, the member that enable the member to obtain and maintain an individual job in competitive employment, customized employment or self-employment in an integrated work setting in the general workforce.

Expected Outcome of Service. The expected outcome of this service is sustained employment, or self-employment, paid at or above the minimum wage or the customary wage and level of benefits paid by an employer, in an integrated setting in the general workforce, in a job that meets personal and career goals. Successful transition to long-term job coaching, if needed, is also an expected outcome of this service. An expected outcome of supported self-employment is that the member earns income that is equal to or exceeds the average income for the chosen business within a reasonable period of time.

Setting. Individual supported employment services shall take place in integrated work settings.

For self-employment, the member's home can be considered an integrated work setting. Employment in the service provider's organization (not including a sheltered workshop or similar type of work setting where members are paid for the production of goods or services) can be considered employment in an integrated work setting in the general workforce if the employment occurs in a work setting where interactions are predominantly with coworkers or business associates who do not have disabilities or with the general public.

Individual employment strategies include but are not limited to:

- Customized employment,
- Individual placement and support, and
- Supported self-employment.

- Career exploration services leading to career advancement outcomes
- Other workplace support services may include services not specifically related to job skill training that enable the waiver member to be successful in integrating into the individual or community setting
- Transportation of the member during service hours

Individual Placement and Support

Individual placement and support (IPS) is a model of supported employment for people with serious mental illness. IPS supported employment helps people living with behavioral health conditions work at regular jobs of their choosing. Although variations of supported employment exist, IPS is the only evidence-based practice of supported employment. IPS is a SAMHSA Evidence-Based Practice and guided by IPS practice principles outlined by the IPS Works Employment Center. <https://ipsworks.org/index.php/what-is-ips/>

IPS shall include:

1. Focus on competitive employment: Agencies providing IPS services are committed to competitive employment as an attainable goal for people with behavioral health conditions seeking employment.
2. Zero exclusion criteria based on client choice: People are not excluded based on readiness, diagnoses, symptoms, substance use history, psychiatric hospitalizations, homelessness, level of disability, or legal system involvement.
3. Integration of rehabilitation and mental health services: IPS programs are closely integrated with mental health treatment teams.
4. Attention to worker preferences: Services are based on each person's preferences and choices.
5. Personalized benefits counseling: Employment specialists help people obtain personalized, understandable, and accurate information about their social security, Medicaid, and other government entitlements.
6. Rapid job search: IPS programs use a rapid job search approach to help job seekers obtain jobs directly, rather than providing lengthy preemployment assessment, training, and counseling.
7. Systematic job development: Employment specialists systematically visit employers to learn about their business needs and hiring preferences.
8. Time unlimited and individualized support: Job supports are individualized and continue for as long as each worker wants and needs the support.

Service Requirements for All Supported Employment Services

Community transportation options (e.g., transportation provided by family, coworkers, carpools, volunteers, self or public transportation) shall be identified by the member's interdisciplinary team and utilized before the service provider provides the transportation to and from work for the member. If none of these options are available to a member, transportation between the member's place of residence and the employment or service location may be included as a component part of supported employment services.

Personal care or personal assistance and protective oversight may be a component part of supported employment services but may not comprise the entirety of the service.

Activities performed on behalf of a member receiving long-term job coaching or individual or small-group supported employment shall not comprise the entirety of the service.

Concurrent services. A member's individual service plan may include two or more types of nonresidential services (e.g., individual supported employment, long-term job coaching, small-group supported employment, prevocational services, and day habilitation). More than one service may not be billed during the same period of time (e.g., the same hour).

Integration requirements. In the performance of job duties, the member shall have regular contact with other employees or members of the general public who do not have disabilities, unless the absence of regular contact with other employees or the general public is typical for the job as performed by persons without disabilities.

Compensation. Members receiving these services are compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

For supported self-employment, the member earns income that is equal to or exceeds the average income for the chosen business within a reasonable period of time.

For small-group supported employment, if the member is not compensated at or above minimum wage, the compensation to the member shall be in accordance with all applicable state and federal labor laws and regulations.

Individuals receiving supported employment must have documented in the service plan a goal to achieve or to sustain individual employment

Additional needs-based criteria for receiving the service, if applicable (*specify*):

Home-based habilitation services shall be available to members based on the member's most current LOCUS/CALOCUS actual disposition score, according to the following criteria:

(1) Intensive IV services are provided 24 hours per day. To be eligible for intensive IV services, a member must meet the following criteria:

1. The member has a LOCUS/CALOCUS actual disposition of level six medically managed residential services, and

2. The member must also meet the eligibility criteria for admission to intensive residential services. To be eligible to receive intensive residential services, an individual shall meet all the following criteria:

(1) The individual is an adult with a diagnosis of a severe and persistent mental illness or multi-occurring conditions.

(2) The individual has had a standardized functional assessment and screening for multi-occurring conditions completed 60 days or less prior to application for intensive residential services, and the functional assessment and screening demonstrates that the individual:

1. Has a diagnosis that meets the criteria of severe and persistent mental illness as defined as a documented primary mental health disorder diagnosed by a mental health professional that causes symptoms and impairments in basic mental and behavioral processes that produce distress and major functional disability in adult role functioning inclusive of social, personal, family, educational or vocational roles. The individual has a degree of impairment arising from a psychiatric disorder such that: (1) the individual does not have the resources or

skills necessary to maintain function in the home or community environment without assistance or support; (2) the individual's judgment, impulse control, or cognitive perceptual abilities are compromised; (3) the individual exhibits significant impairment in social, interpersonal, or familial functioning; and (4) the individual has a documented mental health diagnosis. For this purpose, a "mental health diagnosis" means a disorder, dysfunction, or dysphoria diagnosed pursuant to the current version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association (published 2013, with all changes and updates approved by the American Psychiatric Association through September 2023 incorporated herein), excluding neurodevelopmental disorders, substance use disorders, personality disorders, medication-induced movement disorders and other adverse effects of medication, and other conditions that may be a focus of clinical attention as defined in the current version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association (published 2013, with all changes and updates approved by the American Psychiatric Association through September 2023 incorporated herein).

2. Has three or more areas of significant impairment in activities of daily living or instrumental activities of daily living;

3. Is in need of 24-hour supervised and monitored treatment to maintain or improve functioning and avoid relapse that would require a higher level of treatment;

4. Has exhibited a lack of progress or regression after an adequate trial of active treatment at a less intensive level of care;

5. Is at risk of significant functional deterioration if intensive residential services are not received or continued; and

6. Meets one or more of the following:

- Has a record of three or more psychiatric hospitalizations in the 12 months preceding application for intensive residential services.
- Has a record of more than 30 medically unnecessary psychiatric hospital days in the 12 months preceding application for intensive residential services.
- Has a record of more than 90 psychiatric hospital days in the 12 months preceding application for intensive residential services.
- Has a record of three or more emergency room visits related to a psychiatric diagnosis in the 12 months preceding application for intensive residential services.
- Is residing in a state resource center and has an SPMI.
- Is being served out of state due to the unavailability of medically necessary services in Iowa.
- Has an SPMI and is scheduled for release from a correctional facility or a county jail.

Is homeless or precariously housed.

Categorically needy (*specify limits*):

A unit of home-based habilitation is a day. The member is assigned a Home-Based Habilitation Tier based on the actual disposition score of the LOCUS/CALOCUS tool.

For Intensive IV Tier 7 the member must also meet the eligibility criteria for admission to intensive residential services. To be eligible to receive intensive residential services, an individual shall meet all the following criteria:

(1) The individual is an adult with a diagnosis of a severe and persistent mental illness or multi-occurring conditions.

(2) The individual has had a standardized functional assessment and screening for multi-occurring conditions completed 60 days or less prior to application for intensive residential services, and the functional assessment and screening demonstrates that the individual:

1. Has a diagnosis that meets the criteria of severe and persistent mental illness as defined as a documented primary mental health disorder diagnosed by a mental health professional that causes symptoms and impairments in basic mental and behavioral processes that produce distress and major functional disability in adult role functioning inclusive of social, personal, family, educational or vocational roles. The individual has a degree of impairment arising from a psychiatric disorder such that: (1) the individual does not have the resources or skills necessary to maintain function in the home or community environment without assistance or support; (2) the individual's judgment, impulse control, or cognitive perceptual abilities are compromised; (3) the individual exhibits significant impairment in social, interpersonal, or familial functioning; and (4) the individual has a documented mental health diagnosis. For this purpose, a "mental health diagnosis" means a disorder, dysfunction, or dysphoria diagnosed pursuant to the current version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association (published 2013, with all changes and updates approved by the American Psychiatric Association through September 2023 incorporated herein), excluding neurodevelopmental disorders, substance use disorders, personality disorders, medication-induced movement disorders and other adverse effects of medication, and other conditions that may be a focus of clinical attention as defined in the current version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association (published 2013, with all changes and updates approved by the American Psychiatric Association through September 2023 incorporated herein).

2. Has three or more areas of significant impairment in activities of daily living or instrumental activities of daily living;

3. Is in need of 24-hour supervised and monitored treatment to maintain or improve functioning and avoid relapse that would require a higher level of treatment;

4. Has exhibited a lack of progress or regression after an adequate trial of active treatment at a less intensive level of care;

5. Is at risk of significant functional deterioration if intensive residential services are not received or continued; and

6. Meets one or more of the following:

- Has a record of three or more psychiatric hospitalizations in the 12 months preceding application for intensive residential services.
- Has a record of more than 30 medically unnecessary psychiatric hospital days in the 12 months preceding application for intensive residential services.

- Has a record of more than 90 psychiatric hospital days in the 12 months preceding application for intensive residential services.
- Has a record of three or more emergency room visits related to a psychiatric diagnosis in the 12 months preceding application for intensive residential services.
- Is residing in a state resource center and has an SPMI.
- Is being served out of state due to the unavailability of medically necessary services in Iowa.
- Has an SPMI and is scheduled for release from a correctional facility or a county jail.
- Is homeless or precariously housed.

Tier	Tier 1	Tier 2	Tier 3	Tier 4	Tier 5	Tier 6	Tier 7
Actual Disposition Recommended Level of Care	Level 0	Level 1	Level 2	Level 3	Level 4	Level 5	Level 6
Procedure Code Modifier	H2016 UA	H2016 UB	H2016 UC	H2016 UD	H2016 U8	H2016 U9	H2016 U7
Description	High Recovery	Recovery Transitional	Medium Need	Intensive I	Intensive II	Intensive III	Intensive IV – Intensive Residential Habilitation (IRSH)*
Hours of Staff Supervision and Support	.25 to 2 hours per day as needed	2.25 to 4 hours per day as needed	4.25 to 8.75 hours per day as needed	9 to 12.75 hours per day	13 to 16.75 hours per day	17 to 24 hours per day	24 hours per day
LOCUS Composite Score	07-09	10-13	14-16	17-19	20-22	23 or more	28 or more

* Member must be residing in a designated IRSH setting to receive Intensive IV/level 6 level of care

Home-based habilitation payment shall not be made for the following:

- (1) Room and board and maintenance costs, including the cost of rent or mortgage, utilities, telephone, food, household supplies, and building maintenance, upkeep, or improvement.
- (2) Service activities associated with vocational services, day care, medical services, or case management.
- (3) Transportation to and from a day program.
- (4) Services provided to a member who lives in a licensed residential care facility of more than 16 persons.
- (5) Services provided to a member who lives in a facility that provides the same service as part of an inclusive or “bundled” service rate, such as a nursing facility or an intermediate care facility for persons with mental retardation.
- (6) Personal care and protective oversight and supervision may be a component part of home-based habilitation services but may not comprise the entirety of the service.

The current Fee schedule for Home Based Habilitation may be located online at:
<https://hhs.iowa.gov/medicaid/provider-services/covered-services-rates-and-payments/fee-schedules>

Day Habilitation is reimbursed at 15 min unit of service up to 16 units per day, or Daily (4.25 to 8 hours) The rates for Day habilitation are located at 441 IAC Chapter 79 <https://www.legis.iowa.gov/docs/iac/rule/07-05-2017.441.79.1.pdf>

Day habilitation payment shall not be made for the following:

(1) Services that are available to the individual under a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).

Documentation that funding is not available to the individual for the service under these programs shall be maintained in the service plan of each member receiving day habilitation services.

(2) Compensation to members for participating in day habilitation.

(3) Support for members volunteering in for-profit organizations and businesses.

(4) Support for members volunteering to benefit the day habilitation service provider.

Prevocational services are reimbursed as an hourly unit of service.

Career exploration is an hourly unit of service.

The current HCBS Prevocational and Supported Employment fee schedule may be located at:

<https://hhs.iowa.gov/medicaid/provider-services/covered-services-rates-and-payments/fee-schedules>

Prevocational Service Limitation

There is a time limitation for members starting prevocational services. Participation in these services is limited to 24 calendar months. This time limit can be extended to continue beyond 24 months if one or more of the following conditions apply:

- The member who is in prevocational services is also working in either individual or small-group community employment for at least the number of hours per week desired by the member, as identified in the member's current service plan; or
- The member who is in prevocational services is also working in either individual or small-group community employment for less than the number of hours per week the member desires, as identified in the member's current service plan, but the member has services documented in the member's current service plan, or through another identifiable funding source (e.g., Iowa vocational rehabilitation services (IVRS)), to increase the number of hours the member is working in either individual or small-group community employment; or
- The member is actively engaged in seeking individual or small-group community employment or individual self-employment, and services for this are included in the member's current service plan or services funded through another identifiable funding source (e.g., IVRS) are documented in the member's service plan; or
- The member has requested supported employment services from Medicaid and IVRS in the past 24 months, and the member's request has been denied, or the member has been placed on a waiting list by both Medicaid and IVRS; or
- The member has been receiving individual supported employment services (or comparable services available through IVRS) for at least 18 months without obtaining individual or small-group community employment or individual self-employment; or
- The member is participating in career exploration activities.

Exclusions

- Prevocational services payment shall not be made for the following:
- Services that are available to the individual under a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).
- Documentation that funding is not available to the individual for the service under these programs shall be maintained in the service plan of each member receiving prevocational services.
- Services available to the individual that duplicate or replace education or related services defined in the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).
- Compensation to members for participating in prevocational services.
- Support for members volunteering in for-profit organizations and businesses

Supported Employment (SE) services.

Individual SE is reimbursed as an hourly unit of service.

Small Group SE is reimbursed as a 15 min unit of service.

Long Term Job Coaching SE is reimbursed as a monthly unit of service.

Individual Placement and Support (IPS) SE is reimbursed for each outcome achieved for the member participating in the IPS SE model
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Medically Needy

A unit of home-based habilitation is a day. The member is assigned a Home-Based Habilitation Tier based on the actual disposition score of the LOCUS/CALOCUS tool.

For Intensive IV Tier 7 the member must also meet the eligibility criteria for admission to intensive residential services. To be eligible to receive intensive residential services, an individual shall meet all the following criteria:

- (1) The individual is an adult with a diagnosis of a severe and persistent mental illness or multi-occurring conditions.
- (2) The individual has had a standardized functional assessment and screening for multi-occurring conditions completed 60 days or less prior to application for intensive residential services, and the functional assessment and screening demonstrates that the individual:
 1. Has a diagnosis that meets the criteria of severe and persistent mental illness as defined as a documented primary mental health disorder diagnosed by a mental health professional that causes symptoms and impairments in basic mental and behavioral processes that produce distress and major functional disability in adult role functioning inclusive of social, personal, family, educational or vocational roles. The individual has a degree of impairment arising from a psychiatric disorder such that: (1) the individual does not have the resources or skills necessary to maintain function in the home or community environment without assistance or support; (2) the individual's judgment, impulse control, or cognitive perceptual abilities are compromised; (3) the individual exhibits significant impairment in social, interpersonal, or familial functioning; and (4) the individual has a documented mental health diagnosis. For this purpose, a "mental health diagnosis" means a disorder, dysfunction, or dysphoria diagnosed pursuant to the current version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association (published 2013, with all changes and updates approved by the American Psychiatric Association through September 2023 incorporated herein), excluding neurodevelopmental disorders, substance use disorders, personality disorders, medication-induced movement disorders and other adverse effects of medication, and other conditions that may be a focus of clinical attention as defined in the current version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association (published 2013, with all changes and updates approved by the American Psychiatric Association through September 2023 incorporated herein).
 2. Has three or more areas of significant impairment in activities of daily living or instrumental activities of daily living;
 3. Is in need of 24-hour supervised and monitored treatment to maintain or improve functioning and avoid relapse that would require a higher level of treatment;
 4. Has exhibited a lack of progress or regression after an adequate trial of active treatment at a less intensive level of care;
 5. Is at risk of significant functional deterioration if intensive residential services are not received or continued; and
 6. Meets one or more of the following:

- Has a record of three or more psychiatric hospitalizations in the 12 months preceding application for intensive residential services.
- Has a record of more than 30 medically unnecessary psychiatric hospital days in the 12 months preceding application for intensive residential services.
- Has a record of more than 90 psychiatric hospital days in the 12 months preceding application for intensive residential services.
- Has a record of three or more emergency room visits related to a psychiatric diagnosis in the 12 months preceding application for intensive residential services.
- Is residing in a state resource center and has an SPMI.
- Is being served out of state due to the unavailability of medically necessary services in Iowa.
- Has an SPMI and is scheduled for release from a correctional facility or a county jail.
- Is homeless or precariously housed.

Tier	Tier 1	Tier 2	Tier 3	Tier 4	Tier 5	Tier 6	Tier 7
Actual Disposition Recommended Level of Care	Level 0	Level 1	Level 2	Level 3	Level 4	Level 5	Level 6
Procedure Code/ Modifier	H2016 UA	H2016 UB	H2016 UC	H2016 UD	H2016 U8	H2016 U9	H2016 U7
Description	High Recovery	Recovery Transitional	Medium Need	Intensive I	Intensive II	Intensive III	Intensive IV – Intensive Residential Habilitation (IRSH)*
Hours of Staff Supervision and Support	.25 to 2 hours per day as needed	2.25 to 4 hours per day as needed	4.25 to 8.75 hours per day as needed	9 to 12.75 hours per day	13 to 16.75 hours per day	17 to 24 hours per day	24 hours per day
LOCUS Composite Score	07-09	10-13	14-16	17-19	20-22	23 or more	28 or more

* Member must be residing in a designated IRSH setting to receive Intensive IV/level 6 level of care

Home-based habilitation payment shall not be made for the following:

- (1) Room and board and maintenance costs, including the cost of rent or mortgage, utilities, telephone, food, household supplies, and building maintenance, upkeep, or improvement.
- (2) Service activities associated with vocational services, day care, medical services, or case management.
- (3) Transportation to and from a day program.

(4) Services provided to a member who lives in a licensed residential care facility of more than 16 persons.

(5) Services provided to a member who lives in a facility that provides the same service as part of an inclusive or “bundled” service rate, such as a nursing facility or an intermediate care facility for persons with intellectual disability.

(6) Personal care and protective oversight and supervision may be a component part of home-based habilitation services but may not comprise the entirety of the service.

The current Fee schedule for Home Based Habilitation may be located online at: <http://dhs.iowa.gov/ime/providers/csrp/fee-schedule>

Day Habilitation is reimbursed at 15 min unit of service up to 16 units per day, or Daily (4.25 to 8 hours) The rates for Day habilitation are located at 441 IAC Chapter 79 <https://www.legis.iowa.gov/docs/iac/rule/07-05-2017.441.79.1.pdf>

Day habilitation payment shall not be made for the following:

(1) Services that are available to the individual under a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).

Documentation that funding is not available to the individual for the service under these programs shall be maintained in the service plan of each member receiving day habilitation services.

(2) Compensation to members for participating in day habilitation.

(3) Support for members volunteering in for-profit organizations and businesses.

(4) Support for members volunteering to benefit the day habilitation service provider.

Prevocational services are reimbursed as an hourly unit of service. Career exploration is an hourly unit of service.

The current HCBS Prevocational and Supported Employment fee schedule may be located at: <https://hhs.iowa.gov/medicaid/provider-services/covered-services-rates-and-payments/fee-schedules>

Prevocational Service Limitations

There is a time limitation for members starting prevocational services. Participation in these services is limited to 24 calendar months. This time limit can be extended to continue beyond 24 months if one or more of the following conditions apply:

- The member who is in prevocational services is also working in either individual or small-group community employment for at least the number of hours per week desired by the member, as identified in the member’s current service plan; or
- The member who is in prevocational services is also working in either individual or small-group community employment for less than the number of hours per week the member desires, as identified in the member’s current service plan, but the member has services documented in the member’s current service plan, or through another identifiable funding source (e.g., Iowa vocational rehabilitation services (IVRS)), to increase the number of hours the member is working in either individual or small-group community employment; or

- The member is actively engaged in seeking individual or small-group community employment or individual self-employment, and services for this are included in the member's current service plan or services funded through another identifiable funding source (e.g., IVRS) are documented in the member's service plan; or
- The member has requested supported employment services from Medicaid and IVRS in the past 24 months, and the member's request has been denied, or the member has been placed on a waiting list by both Medicaid and IVRS; or
- The member has been receiving individual supported employment services (or comparable services available through IVRS) for at least 18 months without obtaining individual or small-group community employment or individual self-employment; or
- The member is participating in career exploration activities.

Exclusions

- Prevocational services payment shall not be made for the following:

Provider Qualifications <i>(For each type of provider. Copy rows as needed):</i>			
Provider Type <i>(Specify):</i>	License <i>(Specify):</i>	Certification <i>(Specify):</i>	Other Standard <i>(Specify):</i>
Home-based habilitation providers		<p>Meet any of the following:</p> <ul style="list-style-type: none"> • Accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) • Accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) • Accredited by the Council on Accreditation (COA) • Accredited by the Council on Quality and Leadership (CQL) • Certified by the Iowa Medicaid as a home-based habilitation provider pursuant to 441 IAC 77 * • Certified by the Division of Behavioral Health as a provider of Supported Community Living under 441-IAC 24.2 through 24.4(8) and 24.2(12). 	<p>Direct support staff providing home-based habilitation services shall meet the following minimum qualifications in addition to the other requirements outlined in this rule:</p> <p>(1) A person providing direct support shall be at least 18 years old and have a high school diploma or its equivalent.</p> <p>(2) A person providing direct support shall not be a relative, legally responsible individual, or a legal guardian of the member receiving services.</p> <p>(3) A person providing direct support to members receiving home-based habilitation services shall complete a minimum of 24 hours of training within the first year of employment in mental health and multi-occurring conditions, including but not limited to the following topics:</p> <ol style="list-style-type: none"> 1. Mental health diagnoses, symptomology, and treatment; 2. Intervention strategies that may include applied behavioral analysis, motivational interviewing, or other evidence-based practices; 3. Crisis management, intervention, and de-escalation; 4. Psychiatric medications, common medications, and potential side effects; 5. Member-specific medication protocols, supervision of self-administration of medication, and documentation; 6. Substance use disorders and treatment;
Intensive Residential Service Providers		<ul style="list-style-type: none"> • Meet any of the above and meet the following criteria at initial application and annually thereafter: <ol style="list-style-type: none"> (1) Be a certified or previously qualified home-based habilitation provider in good standing with the Iowa Medicaid. (2) Provide staffing 24 hours a day, 7 days a week, 365 days a year. (3) Maintain a minimum staffing ratio of one staff to every two residents. Staffing ratios shall be responsive to the needs of the individuals served. (4) Ensure that all staff members have the following minimum qualifications: 	

		<p>1. One year of experience working with individuals with a mental illness or multi-occurring conditions.</p> <p>2. A high school diploma or equivalent.</p> <p>(5) Ensure that within the first year of employment, staff members complete 48 hours of training in mental health and multi-occurring conditions. During each consecutive year of employment, staff members shall complete 24 hours of training in mental health and multi-occurring conditions. Staff training shall include, but is not limited to the following:</p> <ol style="list-style-type: none"> 1. Applied behavioral analysis. 2. Autism spectrum disorders, diagnoses, symptomology and treatment. 3. Brain injury diagnoses, symptomology and treatment. 4. Crisis management and de-escalation and mental health diagnoses, symptomology and treatment. 5. Motivational interviewing. 6. Psychiatric medications. 7. Substance use disorders and treatment. 8. Other diagnoses or conditions present in the population served. <p>(6) Provide coordination with the individual's clinical mental health and physical health treatment, and other services and supports.</p> <p>(7) Provide clinical oversight by a mental health professional. The mental health professional shall review and consult on all behavioral health services provided to the individual, and any other plans</p>	<p>7. Other diagnoses or conditions present in the population served; and</p> <p>8. Individual-person-centered service plan, crisis plan, and behavioral support plan implementation.</p> <p>(4) A person providing direct support to members receiving home-based habilitation services shall complete a minimum of 12 hours of training annually on the topics listed in 441 IAC 77, or other topics related to serving individuals with severe and persistent mental illness.</p> <p>(5) A person providing direct support to members receiving intensive residential services shall:</p> <ul style="list-style-type: none"> • Have the following minimum qualifications: <ol style="list-style-type: none"> 1. One year of experience working with individuals with a mental illness or multi-occurring conditions. 2. A high school diploma or equivalent. • Within the first year of employment, staff members will complete 48 hours of training in mental health and multi-occurring conditions. During each consecutive year of employment, staff members shall complete 24 hours of training in mental health and multi-occurring conditions. Staff training shall include, but is not limited to the following: <ol style="list-style-type: none"> 1. Applied behavioral analysis. 2. Autism spectrum disorders, diagnoses, symptomology and treatment. 3. Brain injury diagnoses, symptomology and treatment. 4. Crisis management and de-escalation and mental health diagnoses, symptomology and treatment.
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		<p>developed for the individual, including but not limited to service plans, behavior intervention plans, crisis intervention plans, emergency plans, cognitive rehabilitation plans, or physical rehabilitation plans.</p> <p>(8) Have a written cooperative agreement with an outpatient mental health provider and ensure that individuals have timely access to outpatient mental health services,</p> <p>(9) Be licensed as a substance abuse treatment program pursuant to Iowa Code chapter 125 or have a written cooperative agreement with and timely access to licensed substance abuse treatment services for those individuals with a demonstrated need.</p> <p>(10) Accept and serve eligible individuals who are court-ordered to intensive residential services.</p> <p>(11) Provide services to eligible individuals on a no reject, no eject basis.</p> <p>(12) If funded through HCBS and not licensed as a residential care facility, serve no more than five individuals at a site with approval from Iowa Medicaid.</p> <p>(13) Be located in a neighborhood setting to maximize community integration and natural supports.</p> <p>(14) Demonstrate specialization in serving individuals with serious and persistent mental illness or multi-occurring conditions and serve individuals with</p>	<ol style="list-style-type: none">5. Motivational interviewing.6. Psychiatric medications7. Substance use disorders and treatment.8. Other diagnoses or conditions present in the population served.
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		<p>similar conditions in the same site.</p> <p>*Providers must have delivered Home-based Habilitation services for a minimum of one year or more and be a provider in good standing with Iowa Medicaid to be certified for Intensive Residential Services</p>	
<p>Enabling Technology for Remote Support providers</p>		<p>Providers delivering Enabling Technology needs must be one of the following professionals:</p> <ul style="list-style-type: none"> • Providers enrolled to deliver HCBS BI or ID waiver Supported Community Living • Providers enrolled to deliver HCBS Habilitation Home-Based Habilitation • Others qualified by training or experience to provide enabling technology. 	<p>The support planning team will identify the person(s) or entity experienced in the area of Enabling Technology and its application for people with disabilities as qualified to provide and ensure that:</p> <ol style="list-style-type: none"> a) an evaluation of the participant’s need for an assessment of potential for successful utilization of enabling devices occurs; b) the appropriate and cost-effective device is selected from available options; c) the appropriate device is procured; d) training and technical assistance to the participant, caregiver and staff for the proper utilization of the device occurs; and e) appropriate evaluation methods are developed to assure that the intended outcome(s) of the technology is achieved. <p>Enabling technology equipment services must provide a cost-effective, appropriate means of meeting the needs defined in the member’s person-centered service plan.</p> <p>All items shall meet applicable standards of manufacture, design, and installation.</p>

<p>Day Habilitation providers</p>		<p>Meet any of the following:</p> <ul style="list-style-type: none">• Accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF)• Accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO)• Accredited by the Council on Accreditation (COA)• Accredited by the Council on Quality and Leadership (CQL)• Accredited by the International Center for Clubhouse Development (ICCD)• Certified by Iowa Medicaid as a provider of Day Habilitation for the HCBS ID Waiver under 441-IAC Chapter 77.• Certified by the department as a provider of Day Treatment under 441-IAC 24.2 through 24.4(8) and 24.4(10) or Supported Community Living under 441-IAC 24.2 through 24.4(8) and 24.2(12).	<p>Direct support staff providing day habilitation services shall meet the following minimum qualifications in addition to other requirements outlined in administrative rule:</p> <p>(1) A person providing direct support without line-of-sight supervision shall be at least 18 years of age. A person providing direct support with line-of sight supervision shall be 16 years of age or older.</p> <p>(2) A person providing direct support shall not be a relative, legally responsible individual, or a legal guardian of the member</p> <p>(3) A person providing direct support shall, within six months of hire or within six months of February 1, 2021, complete at least 9.5 hours of training in supporting members in the activities listed in 701— paragraph 78.27(8) “a,” as offered through DirectCourse or Relias or other nationally recognized training curriculum.</p> <p>(4) A person providing direct support shall annually complete 4 hours of continuing education in supporting members in the activities listed in 701— paragraph 78.27(8) “a,” as offered through DirectCourse or Relias or other nationally recognized training curriculum</p>
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<p>Prevocational habilitation providers</p>		<p>Meet any of the following:</p> <ul style="list-style-type: none">• Accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF)• Accredited by the Council on Quality and Leadership (CQL)• Accredited by the International Center for Clubhouse Development (ICCD)• Certified by Iowa Medicaid as a provider of Prevocational services under 441-IAC Chapter 77	<p>Providers responsible for the payroll of members shall have policies that ensure compliance with state and federal labor laws and regulations, which include, but are not limited to:</p> <ol style="list-style-type: none">(1) Subminimum wage laws and regulations, including the Workforce Investment Opportunity Act.(2) Member vacation, sick leave and holiday compensation.(3) Procedures for payment schedules and pay scale.(4) Procedures for provision of workers' compensation insurance.(5) Procedures for the determination and review of commensurate wages. <p>Direct support staff providing prevocational services shall meet the following minimum qualifications in addition to other requirements outlined in administrative rule:</p> <ol style="list-style-type: none">(1) A person providing direct support without line-of-sight supervision shall be at least 18 years of age. A person providing direct support with line-of-sight supervision shall be 16 years of age or older.(2) A person providing direct support shall not be a relative, legally responsible individual, or a legal guardian of the member.(3) A person providing direct support shall, within 6 months of hire or within 6 months of May 4, 2016, complete at least 9.5 hours of employment service training as offered through DirectCourse or through the Association of Community Rehabilitation Educators (ACRE) certified training program.(4) Prevocational direct support staff shall complete 4 hours of
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			continuing education in employment services annually
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<p>Supported employment habilitation providers</p>		<p>Meet any of the following:</p> <ul style="list-style-type: none">• Accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF)• Accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO)• Accredited by the Council on Accreditation (COA)• Accredited by the Council on Quality and Leadership (CQL)• Accredited by the International Center for Clubhouse Development (ICCD)• Certified by Iowa Medicaid as a provider as a provider of Supported Employment for the HCBS ID Waiver under 441-IAC Chapter 77 or the HCBS BI waiver under 441-IAC Chapter 77.	<p>Providers responsible for the payroll of members shall have policies that ensure compliance with state and federal labor laws and regulations, which include, but are not limited to:</p> <ol style="list-style-type: none">(1) Subminimum wage laws and regulations, including the Workforce Investment Opportunity Act.(2) Member vacation, sick leave and holiday compensation.(3) Procedures for payment schedules and pay scale.(4) Procedures for provision of workers' compensation insurance.(5) Procedures for the determination and review of commensurate wages. <p>Direct support staff providing individual or small-group supported employment or long-term job coaching services shall meet the following minimum qualifications in addition to other requirements outlined in administrative rule:</p> <ol style="list-style-type: none">(1) Individual supported employment: bachelor's degree or commensurate experience, preferably in human services, sociology, psychology, education, human resources, marketing, sales or business. The person must also hold nationally recognized certification (ACRE or College of Employment Services (CES) or similar) as an employment specialist or must earn this credential within 24 months of hire.(2) Long-term job coaching: associate degree, or high school diploma or equivalent and 6 months' relevant experience. A person providing direct support
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<p>Individual Placement and Support SE Providers</p>			<p>shall, within 6 months of hire complete at least 9.5 hours of employment services training as offered through DirectCourse or through the ACRE certified training program. The person must also hold or obtain, within 24 months of hire, nationally recognized certification in job training and coaching.</p> <p>(3) Small-group supported employment: associate degree, or high school diploma or equivalent and 6 months' relevant experience. A person providing direct support shall, within 6 months of hire complete at least 9.5 hours of employment services training as offered through DirectCourse or through the ACRE certified training program. The person must also hold or obtain, within 24 months of hire, nationally recognized certification in job training and coaching.</p> <p>(4) Supported employment direct support staff shall complete 4 hours of continuing education in employment services annually</p> <ol style="list-style-type: none">1. Providers shall be accredited to provide supported employment and have provided supported employment for a minimum of two years.2. Providers shall demonstrate adequate funding has been secured for the training and technical assistance required for IPS implementation. Adequate funding is defined as at least the amount required for the start-up of one IPS team to complete all phases of IPS implementation. Evidence of such funding shall be
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			<p>made available to the department at the time of enrollment. Evidence may include a written funding agreement or other documentation from the funder</p> <ol style="list-style-type: none">3. Providers shall receive training and technical assistance throughout IPS implementation from an IPS trainer. Evidence of the IPS team's agreement for such training and technical assistance shall be made available to the department at the time of enrollment.4. Prospective IPS teams shall complete IPS implementation as defined in 441-IAC 77 and as outlined by the IPS Works Employment Center. https://ipsworks.org/index.php/what-is-ips/
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Quality Improvement Strategy

(Describe the state's quality improvement strategy in the tables below):

Requirement	Discovery Activities			Remediation		
	Discovery Evidence (Performance Measures)	Discovery Activity (Source of Data & sample size)	Monitoring Responsibilities	Frequency	Remediation Responsibilities (Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)	Frequency (Analysis and Aggregation)
Service plans address needs of 1915(i) participants, are updated annually, and document choice of services and providers.	SP-1 Number and percent of service plans that accurately address all the member's assessed needs, including at a minimum, health and safety risk factors, and personal goals. Numerator: Number of service plans that accurately address all the member's assessed needs, including at a minimum, health and safety risk factors, and personal goals Denominator: Total number of reviewed service plans	Member service plans are reviewed at a 95% confidence level with +/- 5% margin of error. Data is inductively analyzed and reported to the state.	State Medicaid Agency & Contracted Entity (Including MCOs)	Data is Collected Monthly and Quarterly	The MCO ensures that the Case Manager or Community-based Case Manager has addressed the member's health and safety needs in the member's service or treatment plan. The Medical Services Unit completes a quality assurance desk review of member service plans within 10 days of receipt. The Medical Services Unit sends review results, notification of any deficiency, and expectations for remediation to Contracted Entity (Including MCOs) within 2 business days of completing the review. The Contracted Entity (Including MCOs) addresses any deficiencies with the provider or Case Manager and target training and technical assistance to those	Data is Aggregated and Analyzed Continuously and Ongoing

	<p>SP-2 Number and percent of CAHPS respondents who responded “Yes” on the CAHPS survey to the question 53 “In the last 3 months, did this {case manager} work with you when you asked for help with getting other changes to your services?”.</p> <p>Numerator: Number of CAHPS respondents who responded “YES” on the CAHPS survey to question 53 “In the last 3 months, did this {case manager} work with you when you asked for help with getting other changes to your services?”.</p> <p>Denominator: Total number of CAHPS respondents who were directed to question number 53 due to responding “YES” on the CAHPS survey to question 52 “In the last 3 months,</p>	<p>CAHPS Surveys are reviewed at a 95% confidence level with +/- 5% margin of error. Data is inductively analyzed and reported to the state.</p>	<p>Contracted Entity (Including MCOs)</p>	<p>Data is Collected Monthly and Quarterly</p>	<p>The MCO ensures that the Case Manager or Community-based Case Manager has addressed the member’s changing needs in the member’s service or treatment plan and that services change as necessary to meet those needs.</p> <p>The Medical Services Unit completes a quality assurance desk review of member service plans within 10 days of receipt. The Medical Services Unit sends review results, notification of any deficiency, and expectations for remediation to Contracted Entity (Including MCOs) within 2 business days of completing the review. The Contracted Entity (Including MCOs) addresses any deficiencies with the provider or Case Manager and target training and technical assistance to those deficiencies. General methods for problem correction at a systemic level include informational letters, provider training, and collaboration with stakeholders and changes in policy.</p>	<p>Data is Aggregated and Analyzed Quarterly</p>
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	<p>did you ask this {case manager} for help in getting any changes to your services, such as more help from {personal assistance/behavioral health staff and/or homemakers if applicable}, or for help with getting places or finding a job?''.</p>					
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<p>SP-3: Number and percent of service plans which are updated on or before the member's annual due date. Numerator: Number of service plans which were updated on or before the member's annual due date; Denominator: Number of service plans due for annual update that were reviewed.</p>	<p>Member service plans are reviewed at a 95% confidence level with +/- 5% margin of error. Data is inductively analyzed and reported to the state.</p>	<p>Contracted Entity (Including MCOs)</p>	<p>Data is Collected Monthly and Quarterly</p>	<p>See SP-1 Above</p>	<p>Data is Aggregated and Analyzed Quarterly</p>
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<p>Member service plans are reviewed at a 95% confidence level +/- 5% margin of error. Data is inductively analyzed and reported to the state.</p>	<p>Contracted Entity (Including MCOs)</p>	<p>Data is Collected Monthly and Quarterly</p>	<p>See SP-1 Above</p>	<p>Data is Aggregated and Analyzed Quarterly</p>
<p>SP-4 Number and percent of members whose services were delivered according to the service plan, including type, scope, amount, duration, and frequency specified in the plan.</p>	<p>Numerator: Number of members whose services were delivered according to the service plan, including type, scope, amount, duration, and frequency specified in the plan.</p>	<p>Denominator: Total number of member's service plans reviewed</p>		

<p>Approved March 11, 2026</p>	<p>Contracted Entity (Including MCOs)</p>	<p>Data is Collected Monthly and Quarterly</p>	<p>See SP-2 Above</p>	<p>Data is Aggregated and Analyzed Quarterly</p>
<p>CAHPS Surveys are reviewed at a 95% margin of error confidence level. Data is inductively analyzed and reported to the state.</p>	<p>SP-5: Number and percent of CAHPS respondents who responded with either "MOST" or "ALL" on the CAHPS survey to question 56 "In the last 3 months, did your service plan include . . . of the things that are important to you".</p>	<p>Numerator: Number of CAHPS respondents who responded with either "MOST" or "ALL" on the CAHPS survey to question 56 "In the last 3 months, did your service plan include . . . of the things that are important to you".</p>	<p>Denominator: Total number of CAHPS respondents who responded to the CAHPS survey to question 56 "In the last 3 months, did your service plan include . . . of the things that are important to you".</p>	

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	<p>SP-6: Number and percent of service plans from the HCBS QA survey review that indicated the member had a choice of providers</p> <p>NUMERATOR: Number of service plans reviewed which demonstrate choice of HCBS service providers</p> <p>DENOMINATOR: Total number of service plans reviewed</p>	<p>Member service plans are reviewed at a 95% confidence level with +/- 5% margin of error. Data is inductively analyzed and reported to the state.</p>	<p>Contracted Entity (Including MCOs)</p>	<p>Data is Collected Monthly</p>	<p>See SP-1 Above</p>	<p>Data is Aggregated and Analyzed Quarterly</p>
<p>Providers meet required qualifications.</p>	<p>QP-1: Number and percent of licensed or certified Habilitation providers verified against the appropriate licensing or certification standards prior to furnishing services.</p> <p>NUMERATOR: Number of licensed or certified Habilitation providers</p>	<p>Sampling Size: 100%</p>	<p>Contracted Entity (Including MCOs)</p>	<p>Data is Collected Monthly</p>	<p>Contracted Entities (Including MCOs) manage the provider networks and do not enroll providers who cannot meet the required qualifications. If it is discovered by the Provider Services unit or MCO during the review that the provider is not compliant in one of the enrollment and reenrollment state or federal provider requirements, they are required to correct the deficiency prior to enrollment or reenrollment</p>	<p>Data is Aggregated and Analyzed Quarterly</p>

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<p>Settings meet the home and community-based setting requirements as specified in this SPA and in accordance with 42 CFR 441.710(a)(1) and (2).</p>	<p>SR-1: Number and percent of service plans which indicate that the member resides in a setting that meets the HCB setting requirements.</p> <p>NUMERATOR: Number of service plans reviewed which indicate that the member resides in a setting that meets the HCB setting requirements.</p> <p>DENOMINATOR: The number of service plans reviewed</p>	<p>Member service plans are reviewed annually, and more frequently as member needs require, at a 95% confidence level with +/- 5% margin of error.</p>	<p>Contracted Entity (Including MCOs)</p>	<p>Data is Collected Continuously and Ongoing</p>	<p>Contracted Entities (Including MCOs) ensure that Case Managers have addressed the member's health and safety risks during service authorization. The Iowa Medicaid Medical Services Unit completes the QA Service Plan Desk Review within 10 days of receipt of the information from the member's HCB service provider(s) and the Case Manager. The Iowa Medicaid Medical Services Unit will send the review results to the MCO and the Case Manager within 2 business days of completing the review.</p>	<p>Data is Aggregated and Analyzed Quarterly</p>
<p>SR-2: Number and percent of service plans which indicate that the member is receiving services in a setting that meets the HCB setting requirements.</p> <p>NUMERATOR: Number of service plans reviewed which</p>	<p>Member service plans are reviewed annually, and more frequently as member needs require, at a 95% confidence level with +/- 5% margin of error.</p>	<p>Member service plans are reviewed annually, and more frequently as member needs require, at a 95% confidence level with +/- 5% margin of error.</p>	<p>Contracted Entity (Including MCOs)</p>	<p>Data is Collected Continuously and Ongoing</p>	<p>Contracted Entities (Including MCOs) ensure that Case Managers have addressed the member's health and safety risks during service authorization. The Iowa Medicaid Medical Services Unit completes the QA Service Plan Desk Review within 10 days of receipt of the information from the member's HCB service provider(s) and the Case Manager. The Iowa</p>	<p>Data is Aggregated and Analyzed Quarterly</p>

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	<p>indicate that the member is receiving services in a setting that meets the HCB setting requirements</p> <p>DENOMINATOR: The total number of service plans reviewed</p>				<p>Medicaid Medical Services Unit will send the review results to the MCO and the Case Manager within 2 business days of completing the review.</p>	
<p>The SMA retains authority and responsibility for program operations and oversight.</p>	<p>AA-1: Number and percent of required MCO HCBS PM Quarterly reports that are submitted timely</p> <p>NUMERATOR: Number of MCO HCBS PM Quarterly reports submitted timely.</p> <p>DENOMINATOR: Total number of MCO HCBS PM Quarterly reports due in a calendar quarter.</p>	<p>Contracted Entity and MCO performance monitoring. Sampling: 100% Review</p>	<p>Contracted Entity (Including MCOs)</p>	<p>Data is Collected Monthly</p>	<p>Each operating agency within Iowa Medicaid is assigned state staff to serve as a contract manager. This position oversees the quality and timeliness of monthly scorecards and quarterly contract reports. Further, Iowa Medicaid holds a monthly manager meeting in which the account managers of each contracted unit present the operational and performance issues discovered and remediated within the past month. This allows all state staff to collectively sustain transparent administrative oversight. If the contract manager, or policy staff, discovers and documents a repeated deficiency in</p>	<p>Data is Aggregated and Analyzed Quarterly</p>

<p>The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.</p>	<p>FA-2: Number and percent of clean claims that are paid by the managed care organizations within the timeframes specified in the contract</p>	<p>Sampling: 100%</p>	<p>Contracted Entity (Including MCOs)</p>	<p>Data is Collected Quarterly</p>	<p>Program Integrity reviews claims and evaluates whether there was supporting documentation to validate the claim. The Managed Care Organizations will evaluate their claims. When the Program Integrity unit discovers situations where providers are</p>	<p>Data is Aggregated and Analyzed Quarterly</p>
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<p>NUMERATOR: Number of clean claims that are paid by the managed care organization within the timeframes specified in the contract</p> <p>DENOMINATOR: Total number of managed care provider claims</p>					<p>missing documentation to support billing or coded incorrectly, monies are recouped, and technical assistance is given to prevent future occurrence. When the lack of supporting documentation and incorrect coding appears to be pervasive, the Program Integrity Unit may review additional claims, suspend the provider payments, require screening of all claims, referral to MFCU, or provider suspension. The data gathered from this process is stored in the Program Integrity tracking system and reported to the state on a monthly and quarterly basis.</p>	
<p>FA-3: Number and percent of claims that are reimbursed according to the Iowa Administrative Code-approved rate methodology for the services provided</p> <p>NUMERATOR: Number of paid claims that are reimbursed according to the Iowa Administrative Code approved rate methodology for the</p>	<p>SAMPLING: 100% Sample</p>	<p>Contracted Entity (Including MCOs)</p>	<p>Data is Collected Monthly</p>	<p>See FA-2 Above</p>	<p>Data is Aggregated and Analyzed Quarterly</p>	

<p>The state identifies, addresses and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.</p>	<p>HW-1: Number and percent of IAC-defined major critical incidents identified by the HCBS QIO as requiring follow-up escalation that were investigated as required</p> <p>NUMERATOR:</p> <p>Number of IAC-defined major critical incidents as identified by the HCBS QIO requiring follow-up escalation that were investigated as required;</p> <p>DENOMINATOR:</p> <p>Number of IAC-defined major critical incidents identified by the HCBS QIO requiring follow-up escalation.</p>	<p>MCO reporting and IMPA reports are generated by the HCBS Incident Reporting Specialist. This data on incidents is inductively analyzed at 100%.</p>	<p>Contracted Entity (Including MCOs)</p>	<p>Data is Collected Monthly, Quarterly, and Annually</p>	<p>The HCBS Incident Reporting Specialist analyzes data for individual and systemic issues. Individual issues require communication with the service worker, case manager, or MCO community-based case manager to document all efforts to remediate risk or concern. A follow-up escalation for an FFS or MCO member requires an FFS/MCO request to the provider for additional information if warranted by a CIR submission. If the additional research demonstrates a deficiency within provider policy or procedure, the FFS or MCO will open a targeted review to assist in remediation. If these efforts are not successful, the IR Specialist continues efforts to communicate with the service worker, case manager, or MCO community-based case manager their supervisor, and protective services when necessary. All remediation efforts of this type are documented in the monthly and quarterly reports. The HCBS Specialists conducting interviews conduct individual remediation to flagged questions. In the instance that a flagged question/response</p>	<p>Data is Aggregated and Analyzed Quarterly</p>
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<p>neglect, exploitation, or unexplained death that the HCBS QIO identified as followed up on as required</p> <p>DENOMINATOR: Total number of CIRs that identified a reportable event of abuse, neglect, exploitation and/or unexplained death</p>	<p>MCO reporting and IMPA reports are generated by the HCBS Incident Reporting Specialist</p> <p>Sampling: 95% confidence level with +/- 5% margin of error</p>	<p>Contracted Entity (Including MCOs)</p>	<p>Data is Collected Monthly, Quarterly, and Annually</p>	<p>See HW-1 Above</p>	<p>Data is Aggregated and Analyzed Quarterly</p>
<p>HW-3: Number and percent of members who received information on how to report abuse, neglect, exploitation and unexplained deaths</p> <p>NUMERATOR: Number of members service plans that indicate the members received information on how to report abuse, neglect, exploitation and unexplained deaths</p> <p>DENOMINATOR: Total number of</p>					

<p>Number of critical incidents where root cause was identified</p> <p>DENOMINATOR: Total number of critical incident reports</p>	<p>HW-6: Number and percent of reviewed providers with policies for restrictive measures that are consistent with State and Federal policy and rules, and were followed as written</p> <p>NUMERATOR: Number of providers reviewed that have policies for restrictive measures that are consistent with State and Federal policy and rules, and followed as written</p> <p>DENOMINATOR: Total number of providers reviewed</p>	<p>HCBS QIO Onsite QA review process</p> <p>Sampling size: 95% confidence level with +/- 5% margin of error</p>	<p>Contracted Entity</p>	<p>Data is Collected Monthly, Quarterly, and Annually</p>	<p>A representative sample of member case manager service plans, provider service plans and documentation will be reviewed to identify the existence of Behavioral Support Plans for any restrictive interventions Policies for restrictive measures include restraint, seclusion, restrictive interventions, behavioral interventions and behavioral management plans. The Quality Assurance Review ensures that providers are following State and Federal rules and regulations. In areas where a provider is determined to not be following State and Federal rules and Regulations a corrective action plan is issued to bring them into compliance.</p> <p>Providers issued a Probational Certification may be counted twice, depending upon review cycles.</p>	<p>Data is Aggregated and Analyzed Quarterly</p>
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	<p>HW-8 Number and percent of emergency room visits that meet the definition of a CI where a CIR was submitted.</p> <p>NUMERATOR: Number emergency room visits, that</p>	<p>HCBS QIO IMPA reports are generated by the HCBS Incident Reporting Specialist</p> <p>Sampling size 100%</p>	<p>Contracted Entity</p>	<p>Data is Collected Monthly</p>	<p>HCBS QIO Provider Quality Assurance Reviews</p>	<p>Data is Aggregated and Analyzed Quarterly</p>
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	<p>meet the definition of a CI, where a CIR was submitted;</p> <p>DENOMINATOR: Total number of emergency room visits meeting the definition of CI.</p>					
	<p>HW-9 Number and percentage of Habilitation members who received care from a primary care physician in the last 12 months.</p> <p>NUMERATOR: Number of Habilitation members who received care from a primary care physician in the last 12 months;</p> <p>DENOMINATOR: Number of Habilitation members reviewed.</p>	<p>Iowa Medicaid Data Warehouse</p> <p>Sampling size 100%</p>	<p>Contracted Entity</p>	<p>Data is Collected Monthly</p>	<p>Quarterly Iowa Medicaid Data Warehouse Report</p>	<p>Data is Aggregated and Analyzed Quarterly</p>
<p>An evaluation for 1915(i) State plan HCBS eligibility is provided to all applicants for whom</p>	<p>LC-1: Number and percent of new referrals who had an evaluation indicating the individual 1915(i) eligible prior to receipt of services.</p>	<p>IoWANS and MQUIDS MCO – PCP history system</p>	<p>State Medicaid Agency & Contracted Entity (Including MCOs)</p>	<p>Data is collected quarterly</p>	<p>The data informing this performance measure is pulled from IoWANS and MCO data. The state's Medical Services Unit performs internal quality reviews of initial and annual 1915(i) eligibility determinations</p>	<p>Data is Aggregated and Analyzed Quarterly</p>

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<p>there is reasonable indication that 1915(i) services may be needed in the future.</p>	<p>NUMERATOR: Number of completed needs based eligibility determinations (initial)</p> <p>DENOMINATOR: Total number of referrals for needs-based eligibility determination (initial)</p>	<p>Sample Size: 100%</p>			<p>to ensure that the proper criteria are applied. In instances when it is discovered that this has not occurred the unit recommends that the service worker take steps to initiate a new 1915(i) eligibility determination through communication with the member and physician. General methods for problem correction at a systemic level include informational letters, provider trainings, collaboration with stakeholders and changes in policy.</p>	
<p>The 1915(i) eligibility of enrolled individuals is reevaluated at least annually or if more frequent, as specified in the approved state plan for 1915(i) HCBS.</p>	<p>LC-2: Number and percent of members who have a 1915(i)-eligibility determination completed within 12 months of their initial evaluation or last annual reevaluation.</p> <p>NUMERATOR: Number of completed 1915(i)-eligibility determinations</p> <p>DENOMINATOR: Total number of referrals for needs-based eligibility</p>	<p>FFS – IOWANS and MQUIDS MCO – PCP history system Sample Size: 100%</p>	<p>State Medicaid Agency & Contracted Entity (Including MCOs)</p>	<p>Data is collected quarterly</p>	<p>See LC-1 above.</p>	<p>Data is Aggregated and Analyzed Quarterly</p>

	review						
<p>The processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately.</p> <p>LC-3: Number and percent of initial needs-based eligibility decisions that were accurately determined by applying the approved needs-based eligibility criterion using standard operating procedures</p> <p>NUMERATOR: Number of needs-based eligibility decisions that were accurately determined by applying the correct criteria</p> <p>DENOMINATOR: Total number of reviewed needs-based eligibility determinations.</p>	<p>Sampling size: based on NCQA audit criteria which is 5% or 50 files, whichever is less</p>	<p>State Medicaid Agency & Contracted Entity (Including MCOs)</p>	<p>Data is collected quarterly</p>	<p>See LC-1 above.</p>	<p>Data is Aggregated and Analyzed Quarterly</p>		

System Improvement:
 (Describe process for systems improvement as a result of aggregated discovery and remediation activities.)

	<p>All service providers, case managers and MCO CBCMs, regardless of delivery system (i.e., FFS or managed care), are required to document major and minor incidents and make the incident reports and related documentation available to HHS upon request. Providers, case managers, and MCO CBCMs must also ensure cooperation in providing pertinent information regarding incidents as requested by HHS. MCOs must require that all internal staff and network providers report, respond to, and document critical incidents, as well as cooperate with any investigation conducted by the MCO or outside agency, all in accordance with State requirements for reporting incidents 1915(i) Habilitation Program and all other incidents required for licensure of programs through the Department of Inspections and Appeals.</p> <p>Per Chapter 441 Iowa Administrative Code 77.41(12), ... "major incidents" are defined as an occurrence involving a member that is enrolled in an HCBS waiver, targeted case management, or habilitation services, and that: (1) results in a physical injury to or by the member that requires a physician's treatment or admission to a hospital; (2) results in the death of any person; (3) requires emergency mental health treatment for the member; (4) requires the</p>	Data is collected ongoing	<p>agencies, providers, participants, families, and other interested parties upon request. HHS has oversight for monitoring incidents that affect all Habilitation participants. As part of the quality assurance policies and procedures for HCBS Habilitation remediated by the HCBS Incident Reporting Specialist and HCBS specialists. On a quarterly basis, a QA committee will review data collected on incidents and will analyze data to determine trends, problems and issues in service delivery and make recommendations of any policy changes.</p> <p>The HCBS QIO reviews all critical incident reports as soon as they are reported to HHS. All critical incidents are tracked in a critical incident database that tracks the date of the event, the specific HCBS program the member is enrolled in, the provider (if applicable), and the nature of the event, and follow up provided. If the incident has caused or is likely to cause a serious injury, impairment, or abuse to the member, and if Protective Services (PS) has completed or is in the process of conducting an investigation, the HCBS Specialist will coordinate with PS. If PS is not investigating, the HCBS Specialist will begin an on-site review within two working days of receipt of the report. If it is determined that the member has been removed from immediate jeopardy, the review is initiated within twenty working</p>
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